Ongoing efforts to simplify administrative duties pay off
New rules for patient eligibility verification expected to save $9 billion

By Robert Tennant, MA

Too often, physician practices use inefficient methods to determine if patients are eligible for insurance benefits and to identify their financial responsibility. Current practices include phone calls to health plans, logging on to health-plan websites or not checking patient eligibility at all. The results are not surprising: Staff are burdened with phone calls or excess time logging onto separate health-plan or third-party websites, claims are rejected, and practices experience increased accounts receivable. Help is now available for practices looking to streamline this important eligibility process.

Section 1104 of the Patient Protection and Affordable Care Act of 2010 (ACA) requires the Secretary of the Department of Health and Human Services (HHS) to adopt and regularly update so-called “operating rules” for three sets of healthcare financial and administrative transactions. And the first set of nationally mandated operating rules addresses the electronic transaction for patient insurance eligibility verification and the electronic transaction that requires health plans to identify the status of a claim. The compliance date for this first set of operating rules was Jan. 1. HHS estimates that, once implemented, these operating rules, along with the others mandated in the law, will result in the industry saving more than $9 billion during a 10-year period.

MGMA-ACMPE has been a national leader in promoting administrative simplification to drive out waste from the healthcare system, and we identified patient eligibility as a key area for improvement. Through the Association’s advocacy efforts, the government has begun to address the administrative inefficiencies faced by physician practices.

Verification

Obtaining a copy of a patient’s insurance card does not guarantee payment. Verifying that the insurance coverage is current and the service provided to the patient is covered under the plan is an important component of the intake process. And because patient health insurance identification cards are not standardized, not all cards provide coverage expiration dates or patient copay amounts.

The more coverage and patient financial responsibility information you have, and the faster you get it, the greater your chances are for getting paid the appropriate amount for the services provided. To further simplify the insurance verification process, some practice professionals attempt to verify coverage the day before a patient visit, yet this effort is often hindered by the lack of uniformity among health plans.

Operating rules

Operating rules are defined in the ACA as “the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications.” The initial HIPAA standards provided a foundation for the exchange of eligibility/benefits and claim status information but were not sufficient to meet the needs of physician practices. These new operating rules do not replace the existing HIPAA electronic eligibility standards; instead, they build on the HIPAA standards for requests to a health plan and responses from the health plan (known as the X12N 270 and 271 transactions) to make these communications more predictable and consistent.

Operating rules address gaps in standards, help refine the infrastructure that supports electronic data exchange and recognize interdependencies among transactions. The operating rules address the rights and responsibilities of health plans, clearinghouses and providers, security issues, transmission
standards and formats, response time requirements, exception processing, error resolution and more. Most importantly, these new rules facilitate interoperability among those who exchange healthcare data, significantly reducing both cost and administrative hassles.

The ACA mandates the following operating rules, standards and compliance dates:

**Jan. 1, 2013, for:**
- Eligibility verification
- Health claim status

**Jan. 1, 2014, for:**
- Electronic funds transfers operating rules and standards
- Healthcare payment and remittance advice

**Jan. 1, 2016, for:**
- Healthcare claims or equivalent encounter information
- Coordination of benefits
- Health-plan enrollment/disenrollment
- Health-plan premium payment
- Referral certification and authorization transactions
- New standards for electronic claim attachments

**Background**

Prior to passage of the ACA, industry members had developed a voluntary set of operating rules through the Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange (CAQH CORE). CAQH CORE, which was formed in 2006 and took a multistakeholder approach, developed a broad set of eligibility and claim status business rules. Due to its voluntary nature, not all health plans and clearinghouses adopted the CAQH CORE operating rules. MGMA-ACMPE members and staff serve in leadership positions with CAQH CORE and participate in numerous workgroups.

Operating rules are common in other industries, and CAQH CORE modeled its rules on the financial industry. Several years ago, financial institutions agreed on a set of voluntary business processes to govern consumer services, such as ATMs (through standardizing the networks) and direct-deposit banking processes.

To quicken the adoption process and highlight the fact that many of the largest national health plans supported them, HHS mandated almost all of the voluntary operating rules that CAQH CORE had developed. HHS also named CAQH CORE as the author or coauthor for the remaining ACA-mandated operating rules.

The operating rules that are in effect as of Jan. 1 include the following health-plan requirements:

- Provide additional patient financial responsibility/patient liability information in response to an inquiry and support for more high-volume service type codes. Practices using the operating rules will receive the patient’s remaining deductible amount (plus static copay and coinsurance information) from the health plan along with 39 additional service type codes.
- Require health plans to use a template and common structure for transaction “companion guides” (health-plan-specific implementation guides for the transaction) to ensure a more standardized reference.
- Require a minimum level of system availability. To improve the flow of transactions, health-plan systems must be available a minimum of 86 percent per calendar week, and regular downtime must be published by the health plan.
- Improve patient “matching.” The operating rules normalize the submitted and stored last name (for example, remove special
characters, suffixes/prefixes) before trying to match.

- Provide better information about why a patient match did not occur in an eligibility request; health plans are required to return specified codes for each error condition.
- Provide additional financial responsibility/patient liability information in response to an inquiry and support more high-volume service type codes.
- Require health plans to respond quickly to an eligibility inquiry. Response time is 20 seconds or less for real time and the next morning for batch eligibility transactions made by 9 p.m. the day before.

Health-plan compliance

Although the 1996 HIPAA law included the ability of the government to impose penalties for noncompliance of the electronic transaction standards, no fines were ever levied. The ACA includes new requirements for health plans to offer these operating rules and arms the government with additional enforcement powers and significantly higher potential fines.

One important provision of the ACA requires health plans to prove they are able to abide by these operating rules by filing a statement with HHS certifying that their data and information systems are in compliance with the standards and operating rules. No later than April 1, 2014, HHS is required to assess penalties against health plans that do not certify their compliance through the HHS health-plan certification process.

These penalties are potentially significant. The fine amount equals $1 per covered life until certification is complete. In addition:

- The penalties for deliberate misrepresentation are twice the amount imposed for failure to comply.
- Penalty fees increase annually by the annual percentage increase in total national healthcare expenditures.
- Penalties cannot exceed an amount equal to $20 per covered life (or $40 per covered life for deliberate misrepresentation) on an annual basis.

The advantage to practices

It is an opportune time for practice professionals who want to benefit from these new operating rules and improve their patient insurance eligibility verification and claim-status processes to talk with their practice management system (PM) software vendors. It is important to note that these vendors are not required by law to implement the operating rules. With many practices looking to adopt EHRs and take advantage of meaningful use incentive money, it is a perfect time to review your PM needs.

MGMA-ACMPE has teamed up with the American Medical Association to produce the “Selecting a Practice Management System Toolkit” and “Practice Management System Software Directory” to help you communicate with PM vendors and review PM products. The toolkit includes a five-step guide to optimize the process of selecting PM software, a PM criteria checklist and a sample request for proposal. These resources are free to members and are available at mgma.com/washlink-pmstoolkit.

Get our Government Affairs Department’s list of the top 13 practice-management issues to watch for in 2013 at mgma.com/washlink-virtual.